Understanding
Maternal Depression

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New York State
George E. Pataki,
Governor

Department of Health
Antonia C. Novello, M.D., M.P.H.,
Dr. P.H, Commissioner

New York State
Office of Mental Health
Sharon E. Carpinello, R.N., Ph.D.,
Commissioner

Perinatal depression encompasses a wide range of mood disorders that can affect a woman during pregnancy and after the birth of her child. It includes prenatal depression, the "baby blues," postpartum depression, and postpartum psychosis.

Pregnant and postpartum women have frequent contact with the healthcare system, yet healthcare providers may not know what questions to ask to determine if women are at risk of or suffering from perinatal depression. This fact sheet provides some indicators you can look for.

Differential diagnosis: While many of the symptoms are the same across categories, a woman with postpartum depression experiences these symptoms much more strongly and can be impaired to the point where she is unable to do the things she needs to do every day. Unlike the baby blues, which begin shortly after delivery, and resolve within a couple of weeks, postpartum depression can begin at any time within the first year after giving birth and lasts longer than the blues. While a serious condition, it can be treated successfully with medication and counseling.

A fact sheet for care providers

Types, prevalence and symptoms of perinatal depression

Types & Prevalence	Symptoms	
Prenatal Depression Prevalence: 10-20% of pregnant women	• Crying or weepiness • Sleep problems (not due to frequent urination) • Fatigue • Appetite disturbance	• Loss of enjoyment of activities • Anxiety • Poor fetal attachment • Irritability
"Baby Blues" Prevalence: As high as 80% of new mothers	• Feeling overwhelmed • Irritability • Frustration • Anxiety • Mood lability (ups and downs – mom is elated one minute, and crying the next)	• Feeling weepy and crying • Exhaustion • Trouble falling or staying asleep • **Time Frame** – symptoms usually resolve by two weeks post delivery
Postpartum Depression Prevalence: 10 - 20% of new mothers	• Frequent episodes of crying or weepiness • Persistent sadness and flat affect (mom won't smile) • Fatigue • Feelings of inadequacy or guilt • Sleep disturbances (not due to baby's night awakenings) • Appetite disturbances • Irritability • Mood instability • Overly intense worries about the baby • Difficulty concentrating or making decisions • Lack of interest in the baby, family or activities	• Anxiety may manifest as bizarre thoughts and fears, such as obsessional thoughts of harm to the infant • Poor bonding with baby: No attachment • Feeling overwhelmed • Thoughts of death or suicide • May also present with somatic symptoms, e.g., headaches, chest pains, heart palpitations, numbness and hyperventilation. • **Time Frame** – If symptoms lasts more that 14 days it is postpartum depression
Postpartum Psychosis Prevalence: 1-2 per 1,000 new mothers	• **Psychiatric emergency: psychiatric hospitalization necessary** • Auditory hallucinations and delusions (often about the baby, and often of a religious nature) • Visual hallucinations (often in the form of seeing or feeling a presence or darkness) • Insomnia • Feeling agitated and angry • Anxiety • Paranoia (a paranoid delusional system may inhibit her from sharing her delusion)	• Delirium (waxing and waning symptomatology: appears normal one moment and is floridly psychotic the next) • Confusion • Mania (hyperactivity, elated mood, restlessness) • Suicidal or homicidal thoughts • Bizarre delusions and commands to harm the infant (not just an obsessional thought)

If the condition is interfering in any way with the woman's ability to do what she needs to do it might be serious. Do not be afraid to ask if the woman has had suicidal ideation or is obsessed with thoughts of harming herself or her baby. A gentle way to ask this is "some women have thoughts of harming themselves or their baby. Does this happen to you?"

Postpartum psychosis usually presents within the first few days to a month after delivery, but can occur anytime during the first year. Symptoms may appear abruptly. This disorder has a 5% suicide rate and a 4% infanticide rate. Postpartum psychosis is a severe but treatable emergency and requires immediate admission to a psychiatric facility, possibly requiring 24-hour observation. **If you suspect a woman might be experiencing postpartum psychosis, she must be separated from her infant and provided with immediate assistance. Because of the labile and paranoid quality of the psychosis, a mom can appear normal, but then walk into another room and harm her baby. Arranging for childcare and adult assistance in the home is not enough**. An important risk factor for postpartum psychosis is a personal or familial history of bipolar illness (manic depression).

Risk Factors for perinatal depression:
Prior episodes of postpartum depression, depression during pregnancy, personal or family history of depression, unplanned pregnancy, complications during pregnancy or childbirth, preterm birth, abrupt weaning, poor support from a partner, being a single parent, having a history of severe PMS, experiencing multiple or stressful life events, social isolation, history of childhood trauma or abuse, and substance abuse.

Treatment of maternal depression: The two most common forms of treatment are psychotherapy and medications. The type of treatment will depend on the severity of the depression. If a woman is pregnant, plans on breastfeeding, or is breastfeeding, she needs to consult with a qualified physician who is knowledgeable about the latest research on the teratogenic effects of psychotropic medications. In some cases, it is safer to start or continue a medication during and after the pregnancy rather than risk a relapse. It might be helpful to encourage non-clinical interventions such as rest, exercise, or a change in diet. Encourage her to ask for help when she needs it. It may also be helpful to refer a woman to a support group where she can talk with other women who may be having similar experiences. This will let her know that she is not alone.

Local Resources:

Call the state's Growing-Up Healthy Hotline **(1-800-522-5006)** for a local mental health provider.

Crisis situations Please contact the following local agencies for crisis situations:

Albany County:
Albany County Mobile CrisisUnit
518-447-9650

Rensselaer County:
Crisis Line of the Crisis Department, Samaritan Hospital
518-271-3540

Schenectady County:
Ellis Hospital Mental Health Clinic
518-243-3300

Other Hotlines:

Mental Health Association of New York City
1-800-273-TALK (8255)

Hopeline
1-800-SUICIDE (784-2433)

Samaritans Suicide Prevention Center
518-689-4673

Additional information on postpartum depression is available from the following organizations:

Maternal Infant Network of the Capital Region
www.pregnancyandbabies.org
518-426-1153

Postpartum Resource Center of New York, Inc.
www.postpartumny.org
or **631-422-2255**

Mental Health Association of New York State, Inc.
www.mhanys.org
or **518-434-0439**

Postpartum Support International
www.postpartum.net
or **805-967-7636**

National Institute of Mental Health
www.nimh.nih.gov
or **301-496-9567**

The National Women's Health Information Center
www.4woman.gov
or **800-994-9662**

American Psychological Association
www.apa.org
or **800-374-2721**

American College of Obstetrics and Gynecologists
www.acog.com or **800-762-2264**

It is very important to treat maternal depression. There is evidence that links untreated maternal depression to detrimental effects on children. They are at higher risk for developing serious developmental, behavioral, and emotional problems. When a depressed mother goes untreated, the whole family is affected, and the quicker the mother gets treatment, the better the prognosis for the entire family.

Information on Screening for Perinatal Depression:

How and Why?

As a healthcare provider, you may be the first to recognize signs of depression. Screening tools can help you introduce the subject of depression and can be incorporated into the battery of questions that are routinely asked at visits. Screening is an easy, quick, and affordable method of identifying women who may be struggling with depression. While there is no "perfect" screening tool, and research is limited on effectiveness, the Edinburgh Postnatal Depression Scale (EPDS), a 10 question self-report test, and the Postpartum Depression Screening Scale (PDSS), a 35-question self-report test, were both created specifically for new mothers and are showing promise in health care settings.

It is important to note that screening does not replace a diagnostic interview, but it can help to identify women who are at risk and in need of further intervention or referral to mental health services.

Barriers to Treatment

Women (and their healthcare team) may not always recognize that the common effects of pregnancy such as fatigue, lack of energy, poor sleep, and loss of appetite can mask depression. Before dismissing these symptoms as normal for new mothers, an effort should be made to assure that additional symptoms indicative of depression are not present. Conversely, some illnesses, such as thyroid malfunction, may mimic depression, and a complete physical exam may be necessary to rule out any medical causes for the symptoms.

A woman who recognizes that she has symptoms of depression may be inhibited by denial, shame, fear, and/or lack of energy from discussing her symptoms with her provider. Women should be encouraged to be open about their feelings, to seek help, and to feel that depression is not shameful and does not make her a bad mother. Many women may delay acknowledging the symptoms of depression or seeking help in hopes that the symptoms will pass with time, not realizing that time may just exacerbate their condition. Women should be informed that treatment is successful with 80 to 90% of patients, and the earlier that treatment is initiated, the quicker the recovery.

While referral resources may not be readily available in all areas, consultation with mental health staff from a local hospital or clinic may provide valuable support and services. Depending on the case, arranging for a therapist or caseworker to check in periodically with the patient might be advisable. Uninsured women or those on Medicaid may have fewer options for selecting a mental health care provider, but County Mental Health Departments will be able to assist with these cases.

Road to Recovery

Successful treatment of maternal depression requires an awareness of how common the disorder is, identifying symptoms accurately, and initiating treatment quickly. Since depression occurs across all age, race, ethnic and economic groups, every new mother should be screened and educated about perinatal depression. Prenatal visits, the postpartum checkup and routine well-baby visits are ideal times for healthcare staff to discuss and look for the signs of depression. If you recognize signs of depression in one of your patients, ask her about them and reassure her that help exists and she is not alone. Your screening and intervention could make all the difference in the world to women experiencing perinatal depression, and to their families.

For more information on depression screening tools, please go to:

www.perinatalweb.org/foundation/pmdresources.htm#Tools
(includes the EPDS and the Center for Epidemiological Studies-Depression Scale (CES-D)

https://www-secure.earthlink.net/www.wpspublish.com/Inetpub4/catalog/W-380.htm
(describes the Postpartum Depression Screening Scale (PDSS) and how to order it)

www.aafp.org/afp/20020915/1001.html
(describes psychometric properties of various depression screening tools)